NORTHAMPTON COMMUNITY COLLEGE

Lehigh Carbon COMMUNITY COLLEGE

HEALTH FORM

VETERINARY TECHNICIAN PROGRAM

PART I – REPORT OF MEDICAL HISTORY

Please complete *(print all sections)*. **International students: please provide all health documents translated into English.**

Student Name:_____ **Student ID #**:_____
Last *First* *Middle*

Home Address: _____ Gender: ☐ Male ☐ Female ☐ Other_____

City/State/Zip: _____ Preferred: ☐ He/Him ☐ She/Her ☐ They/Them

Home Phone:_____ Cell Phone:_____

Email Address: _____ **Date of Birth**:_____

Program:_____**Veterinary Technician**_____ Campus**:** ☐ **NCC Student** ☐ **LCCC Student**

Semester: Year_____ ☐ FA ☐ SP ☐ SU NCC On-Campus Housing: ☐ Yes ☐ No

I. EMERGENCY NOTIFICATION

Name of Contact:_____ Relationship:_____

Home Address:_____ City/State/ Zip:_____

Primary Phone:_____ Alternate Phone:_____

II. MEDICAL HISTORY – Please answer yes or no to all questions and insert the year for all positive answers:

	Yes	No	Please Explain
Allergies			
Asthma			
Cardiac			
Chemical Dependency			
▪ Drugs			
▪ Alcohol			
Diabetes Mellitus			
Gastrointestinal Disorder			
Hearing Disorder			
Hypertension			
Neuromuscular			
Orthopedic Condition			
Respiratory Illness			
Seizure Disorder			
Vision Disorder			
Other (Specify)			

It is the student's responsibility to inform Program Director of any possible pregnancy prior to 2nd year of Program

ACCIDENT AND HEALTH INSURANCE (Required) – Student must upload a copy of current health insurance card (front and back) to myRecordTracker®. Student is required to have valid health insurance for the duration of the program, and must notify the Program Director and the Health and Wellness Center of any change in health insurance which occurs during the program, and upload a copy of the new insurance card.

If the above named emergency contact cannot be reached at the time of an emergency, the College is authorized to send the above named student to the nearest hospital and/or to administer necessary emergency care. In addition, I authorize the release of information regarding my health/medical status to the Program Director and appropriate designee(s), to the Northampton Community College Health and Wellness Center, to the appropriate health care agency in which I am completing clinical requirements, and/or to the above named emergency contact.

_____ _____

Student signature (Parent/Guardian if under 18 years of age) *Date*

PART II-REPORT OF MEDICAL EXAMINATION

An examination by a licensed medical provider (MD, DO, CRNP, or PA) is **required within 6 months of entry into the clinical practice**. Clinical work is **PROHIBITED** until the required medical forms are received.

Name:_____ **Student ID:**_____ **DOB:**_____

I. Height_____ Weight_____ Blood Pressure_____ Pulse_____

II. Vision Uncorrected R _____ L _____
Corrected R _____ L _____

III. Clinical Examination: *Describe details of abnormalities* **Date of Examination**:_____

	Normal	Abnormal	Comments
Skin			
Head and scalp			
Eyes			
Ears/Hearing			
Mouth, Nose, Throat			
Neck			
Heart			
Lungs			
Abdomen			
Genitourinary			
Musculoskeletal			
Neurological			
Psychiatric			
Exposure to Hepatitis A, B, or C			*If positive for exposure, please submit titers.*

Medication/Allergies	
Medications taken on a regular basis	

IMPORTANT PHYSICIAN PLEASE CHECK APPROPRIATE BOX AND INITIAL	YES	NO	INITIALS
I certify that the applicant has no medical conditions or restrictions (including pregnancy) which will prevent the applicant from performing the essential functions of the job. (If the applicant has restrictions that require accommodation, please note below.)	☐ Yes	☐ No	
Comments *(if applicant has any limitations, please explain)*:			

Health Requirements	Date Administered
TDAP-Tetanus Diptheria Acellular Pertussis *(Dated within 10 years)* – NCC and LCCC students	

Please print, type or stamp:

Name of Licensed Provider_____

Address:_____

Phone_____

Signature of Licensed Provider_____ Date_____

Please upload completed form to www.myrecordtracker.com.
(NCC and LCCC students)